

# Authorization for the Administration of Medicine by School Personnel

## Mansfield Public Schools

Connecticut State Law and Regulations 10-212(a) requires a written medication order of an authorized prescriber (physician, dentist, advanced practice registered nurse, optometrist, or physician's assistant and, for interscholastic and intramural athletic events only, a podiatrist) and parent/guardian written authorization for the nurse (or, in the absence of the nurse, other qualified personnel in accordance with state law and regulations) to administer medication in school. Coaches and licensed athletic trainers during intramural and interscholastic athletic events may administer medications, including inhalant and/or cartridge injector (i.e., Epi-pen) medications, for students. **Medications must be in the original properly labeled container and dispensed by a physician/pharmacist. A parent or responsible adult must bring the medication to the school nurse or principal. Medications to be administered by a coach or athletic trainer must be delivered by a parent or guardian directly to the coach or athletic trainer.**

Please refer to the Board of Education Policy concerning the Administration of Medication in Schools for specific information regarding the administration of medication.

### Prescriber's Authorization

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Medication/Food Allergies ☐ No ☐ Yes \_\_\_\_\_

Medication Name: \_\_\_\_\_ Generic Name: \_\_\_\_\_

Condition for which drug is being administered: \_\_\_\_\_

Dose: \_\_\_\_\_ Route of administration: \_\_\_\_\_

Frequency/Time of Administration: \_\_\_\_\_ If PRN, frequency: \_\_\_\_\_

Relevant side effects: ☐ None expected ☐ Specify: \_\_\_\_\_

Medication shall be administered from: \_\_\_\_\_ to \_\_\_\_\_  
Month/Day/Year Month/Day/Year

Prescribers Name/Title: (type or print) \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

Prescriber's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Use for Prescriber's Stamp

### PARENT / GUARDIAN AUTHORIZATION

I hereby request that the above ordered medication be administered by school personnel. **I understand that:** I must supply the school with no more than a three-month supply of medication; and this medication will be destroyed if not picked up within one week following termination of the order or the last day of school, whichever comes first. By signing below, I give my permission for the exchange of information between the prescriber and the school nurse necessary to ensure safe administration of such medication.

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Home/Cell Phone #: \_\_\_\_\_ Work #: \_\_\_\_\_

### SELF-ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be reviewed and/or approved by the school nurse in accordance with Board policy. For example, asthma inhalers and Epi-pens for sting or nut allergies may be self-carried. Controlled drugs may not be self-administered, except in extraordinary situations with the pre-approval of the medical advisor and nurse supervisor.

Prescriber's authorization for self-administration ☐ Yes ☐ No \_\_\_\_\_

Signature

Date

Parent/Guardian authorization for self-administration ☐ Yes ☐ No \_\_\_\_\_

Signature

Date

School nurse review/approval for self-administration ☐ Yes ☐ No \_\_\_\_\_

Signature

Date